SUPRA-VAGINAL HYSTERECTOMY.

Hysteromyomectomy with Suspension of the Stump in the Lower Angle of the Abdominal Incision.

BY

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GYNECOLOGIST TO THE JOHNS HOPKINS HOSPITAL, BALTIMORE.

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THE method here proposed[1] is limited to cases conceded to be most favorable for operation—those in which there naturally exists a pedicle, or in which it is possible to form a pedicle below the tumor masses. I do not wish to consider atypical cases, in which total ablation of the uterus (panhysterectomy) is called for, or those in which the uterus from fundus to cervix is a mass of fibroid tumors. I also purposely avoid the important question as to the best method of forming a pedicle when the broad ligament is choked with fibroid tumors. Fig. 1 is a generic representation of the class under discussion.

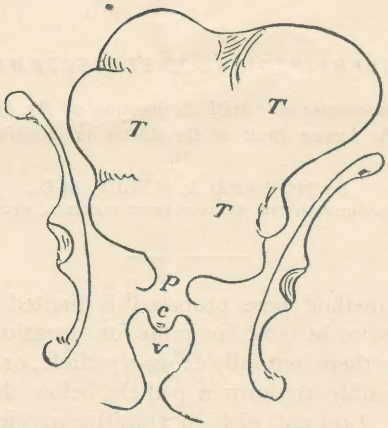
I have adopted in these cases an original method combining the advantages and eliminating many of the dangers of Hegar's and Schröder's methods—the ordinary extra- and intra-peritoneal methods.

The operation consists of seven steps, as follows:

First. A long incision in the linea alba (Fig. 2) for the delivery of the myomatous uterus.

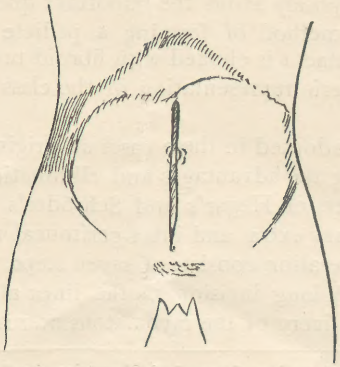
[1] See American Journal of Obstetrics, April, 1889.

FIG. 1.



T T T, tumor. *P*, pedicle. *V*, vagina in section.

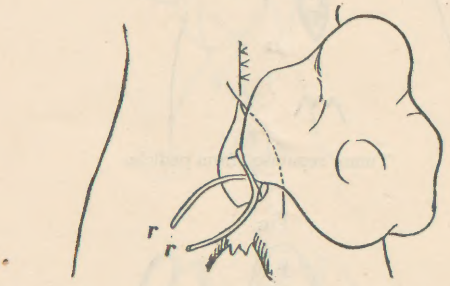
FIG. 2.



Second. The elevation of the tumor until the pedicle is brought into view for treatment by tying the broad ligament structures, or for enucleation of tumors from the broad ligament until a pedicle is formed, when the rubber ligature is applied and tied tightly, controlling the circulation. (Fig. 3.)

Third. The tumor is cut away from one to two inches above the rubber ligature (Fig. 4), by first

FIG. 3.



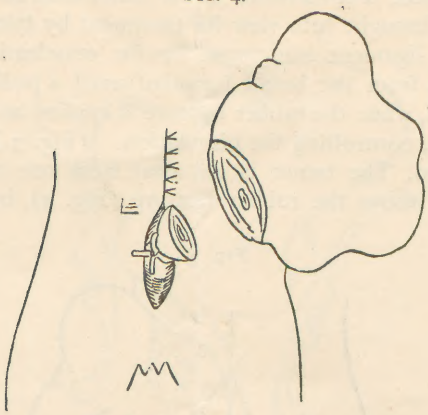
Tumor delivered. *r r*, rubber ligature in place and ready to be drawn tight. · Dotted line shows the incision through the peritoneum.

splitting the peritoneum and then cupping out the upper face of the stump, cutting with each stroke down toward the vaginal canal.

The cervical canal must next be carefully dissected out and its site well cauterized.

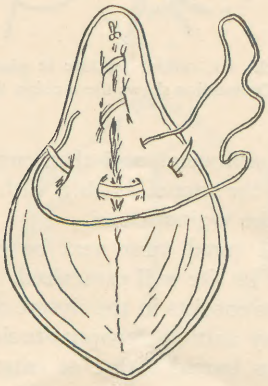
Fourth. This consists in the closure of the raw face of the stump by uniting the opposite sides by means of a continuous buried suture of catgut as seen in Figs. 5 and 6. Fig. 5 represents the appearance seen upon looking down on the stump from above,

FIG. 4.



Tumor separated from pedicle.

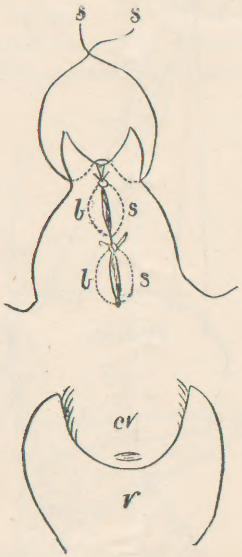
FIG. 5.



Method of closing upper raw surface of stump by means of a continuous buried suture.

Fig. 6 being a vertical section through the cervix. The last row of sutures, which brings the peritoneal surfaces into apposition, is of interrupted silk sutures, with the long ends left uncut, for a purpose to be

FIG. 6.



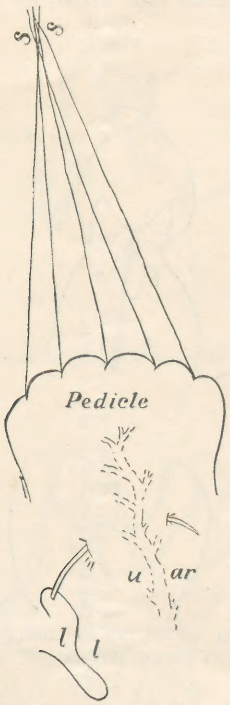
Stump united up to last row of interrupted surface-sutures, *S S*. *b s*, last rows of buried sutures. *V*, vagina. *c v*, vaginal cervix.

described later. All of these sutures, buried and superficial, must be applied with the view of controlling the circulation as well as securing approximation. They must, therefore, be drawn tight, and must encircle any vessels in view.

*

Fifth. After the surface of the stump has thus been closed and there remains nothing of the

FIG. 7.

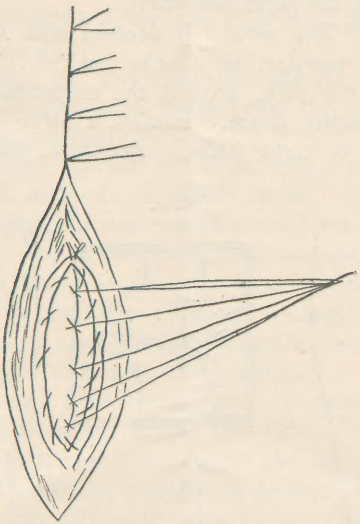


Ligation of left uterine artery. Pedicle is pulled toward the right by means of the long interrupted silk sutures *S S*, while the needle carrying ligature is passed under the uterine artery.

wound but the linear union of the peritoneal surfaces, the rubber ligature is cut away, and the lips

of the wound are carefully observed. If there is any persistent oozing the nearest uterine artery must be ligated. This is accomplished by grasping the long ligatures and pulling the stump to the right or left, exposing the site of the left or right artery. A stout needle armed with a catgut ligature is then swept boldly through the side of the stump, well below the sutured area (Fig. 7) and tied, thus cutting off all communication between the artery and the stump.

FIG. 8.



Showing union of the peritoneal surface of the stump to the parietal peritoneum.

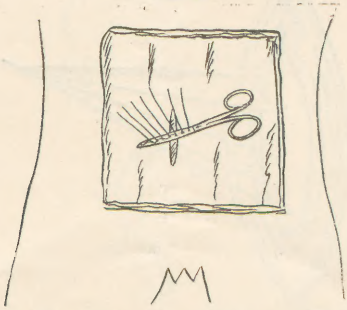
Both arteries may be treated in this way without any danger of destroying the vitality of the stump.

If, however, there should be no flow of blood from the closed lips of the stump, the fifth step may be omitted.

Sixth. The abdominal incision is closed down to the stump, putting in a drainage-tube, if needed, well above the stump. Following this the parietal peritoneum of the abdominal incision is united to the peritoneal coat of the stump, below the lips of the stump, by means of a continuous catgut or silk ligature (Fig. 8); and in this way the stump is separated from the peritoneal cavity.

Seventh. The wound is dressed with some dry antiseptic powder, or simply packed under the edges of the skin, around the suspended stump, with antiseptic gauze. Finally, a large square of gauze, six or eight folds in thickness, with a small

FIG. 9.



Dressing applied. Interrupted sutures of the surface of stump are brought through a hole in the gauze and grasped by forceps.

slit in it, is prepared, and the long ligatures which unite the peritoneal lips of the stump are pulled

through the slit. These are lifted well up, and grasped by a pair of long Keith's forceps laid horizontally on the body (Fig. 9).

This dressing serves effectually to keep the stump from pulling back into the abdomen, and the operator has at all times full control of it at a moment's notice in case of accident. This gauze can be changed as often as soiled. Once every two or three days is usually sufficient. The silk sutures uniting the peritoneal lips of the wound finally either come away or are cut loose and pulled out in about ten days.

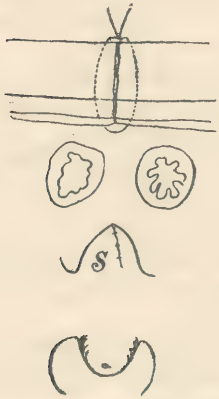
The small pit which is thus left in the lower angle of the abdominal wound over the stump rapidly fills by granulation.

This method has distinct advantages over internal or external methods commonly in use. It is better than dropping the stump back among the intestines (Fig. 10). By the new method hæmorrhage is not dangerous, being at all times under control. The danger of sepsis is also removed, a danger to which large numbers of cases have succumbed after the intra-peritoneal treatment of the stump.

It is better than the common external method (Fig. 11), because, in the first place, it is there necessary to elevate even a short pedicle far enough to attach the parietal peritoneum *below the rubber ligature*. By my method the attachment is higher, and the method is, therefore, better for short pedicles, doing away with a traction which is often excessive.

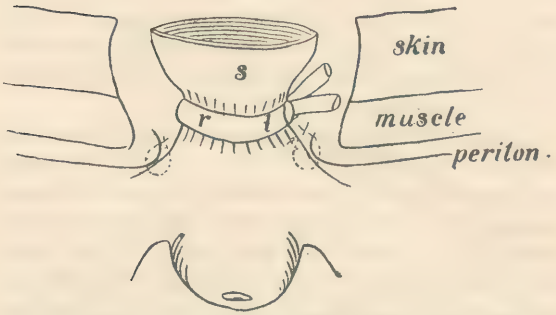
Again, when the rubber ligature is left on, it is impossible to limit the depth of the slough which

FIG. 10.



Intra-peritoneal treatment. Stump *S* dropped back into peritoneal cavity and abdominal walls closed above.

FIG. 11.



Extra-peritoneal treatment of stump *S*, which sloughs off at the rubber ligature *r l*. The union of the peritoneum of the stump to that of the abdominal walls is shown by the dotted circles.

takes place as the distal end drops off, and it will readily be granted on general principles that a method which constricts any part of the body, and waits for it to drop off by sloughing is a coarse and unscientific means of performing an amputation.

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